

## **Impact of the FairTax on Health Care**

The current tax system drives the structure of the existing health care system. We have a health care market that is subject to only restrained price competition and has almost no publicly available information concerning the quality of health care providers. Insured consumers do not bear the financial burden of their purchase decisions and have virtually no incentive to economize in their use of health care services. The change to a federal sales tax system will have a major impact on the health care industry. This analysis examines the impact on health consumers and providers, including hospitals, medical professionals, health insurance companies and pharmaceutical companies.

### **The Present System**

The value of employer provided health insurance and the benefits received thereunder are not taxable to the employee as income.<sup>1</sup> In contrast, if an individual purchases health insurance for himself, he must purchase it out of after-tax dollars. Accordingly, there is a large tax advantage to employer provided health insurance as opposed to either employee purchased insurance or cash compensation.

In 1997, a series of new requirements relating to group health plan portability, access and renewability took effect.<sup>2</sup> In general, these requirements impose strict constraints on pre-existing condition exclusions by group health plans and prohibits plans from discriminating against individuals based on health status. These requirements are directed at alleviating the job “lock-in” effect of employer provided health insurance caused by the tax preference.<sup>3</sup>

Medical Savings Accounts (MSAs) are available to small employers, their employees and self-employed persons.<sup>4</sup> MSAs are paired with high-deductible health insurance policies.<sup>5</sup> A taxpayer who itemizes may deduct the medical and dental expenses of himself, his spouse and dependents to the extent that they exceed 7.5 percent of adjusted gross income.<sup>6</sup> Otherwise, payments for medical services or medications made directly to health care providers must be paid out of after-income-tax dollars.

For-profit hospitals, health insurance companies and pharmaceutical companies are subject to the corporate income tax. The so-called orphan drug credit provides an income tax credit equal to

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<sup>1</sup> Internal Revenue Code §104(a)(3).

<sup>2</sup> Chapter 100 of the Internal Revenue Code (§§9801-9806).

<sup>3</sup> The changes were also motivated by concern for those who lost their jobs involuntarily. In this case also, the fact that the policy is owned by the employer rather than the insured is the reason that corrective legislation was considered necessary.

<sup>4</sup> Internal Revenue Code §220.

<sup>5</sup> A high deductible policy is defined as one with an annual deductible of at least \$1,500 and no more than \$2,250 for individuals and at least \$3,000 and no more than \$4,500 for families.

<sup>6</sup> Internal Revenue Code §213. These rules had been substantially more liberal prior to the Tax Reform Act of 1986.

50 percent of the clinical testing expenses for drugs that address a rare disease or condition.<sup>7</sup> In addition, firms conducting medical or pharmaceutical research and experimentation are eligible for a credit to the extent they increase their research expenditures over a four-year moving base.<sup>8</sup>

Hospitals can be organized as for-profit businesses or as not-for-profit organizations.<sup>9</sup> There is no legal requirement that a not-for-profit hospital conduct its affairs substantially differently from a for-profit hospital except that the net earnings of a not-for-profit hospital cannot inure to the benefit of a private shareholder or individual.<sup>10</sup>

### **Sales Tax Treatment**

Under the FairTax plan, purchases of health care services made directly by an individual will be subject to sales tax just as they generally must be paid from after-income tax dollars today. Health insurance premiums would be subject to tax.<sup>11</sup> Reimbursements to the insured person would be eligible for a tax credit (in effect refunding the tax paid when the individual paid for the medical services directly).<sup>12</sup> If the insurance company paid a doctor or hospital directly, the transaction would not be subject to tax (since the tax on those medical services would have been paid by taxing the entire insurance premium that funded the purchase of the services).<sup>13</sup>

Of course, the most fundamental change would be that all participants in the health care industry whether hospitals, pharmaceutical companies, insurance companies, doctors, nurses or other workers would pay neither individual, corporate income taxes nor payroll taxes (including Social Security and Medicare payroll taxes).

### **Analysis**

In 1980, the U.S. spent 9.1 percent of its Gross Domestic Product (GDP) on health care. In 1998, the United States spent more than 14 percent of GDP on health care (or one in every seven dollars spent).<sup>14</sup> We spend a higher percentage of our income on health care than any other

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<sup>7</sup> Internal Revenue Code §45C.

<sup>8</sup> This credit applies to all qualified research and experimentation. There are actually two alternative methods and sub-credits. Moreover, this credit has expired and been re-enacted many times.

<sup>9</sup> See §501(a) and §501(c)(3).

<sup>10</sup> It is under no legal obligation to provide care for the poor, provide any pro bono care or otherwise conduct its operation differently from the for-profit firm.

<sup>11</sup> This would be equally true of health insurance policies purchased by an employer on behalf of an employee.

<sup>12</sup> Administratively, the insurer would include the credit in the claim payment to the insured and receive a refund on its return. The insurer could elect not to do so and have the insured file for the credit.

<sup>13</sup> For a more detailed discussion, see "Impact of the FairTax on the Financial Services Industries," Americans For Fair Taxation's position paper.

<sup>14</sup> Organization for Economic and Cooperation Development (OECD), Statistical Abstract of the United States, 1999, Table 1355, p. 838.

country on earth, including Canada (9.3), Great Britain (6.9), France (9.6), Germany (10.6), Sweden (8.6) and Japan (7.4).<sup>15</sup> The U.S spends \$3,498 per person, 52 percent more per person than the next highest, Switzerland, at \$2,294.<sup>16</sup> U.S. *public* health care expenditures are comparable to those of other industrialized countries. In 1998, Government in the U.S. spent 6.5 percent of GDP on health care compared to Canada (6.5) Great Britain (5.8), France (7.1), Germany (8.1), and Japan (5.8).<sup>17</sup> U.S. life expectancy at birth is 76.3 years compared to Canada (79.6) Great Britain (77.5), France (78.8), Germany (77.3) and Japan (80.2).<sup>18</sup> The infant mortality rate in the U.S. is 6.7 compared to Canada (5.4), Great Britain (5.7), France (5.6), Germany (5.1) and Japan (4.1).<sup>19</sup> The U.S. spends about 50 percent more than other industrialized countries on health care but has lower life expectancies and higher infant mortality than comparable countries. These are, admittedly, crude measures of the efficacy of a health care delivery system but it is a fact that the U.S. spends much more on health care than other industrialized countries and by at least two measures, U.S. citizens fare worse.

A reasonable hypothesis is that the nature of the U.S. health care delivery system bears at least part of the responsibility for its relatively high costs.<sup>20</sup> More than half of health care expenditures in the U.S. are funded by the private marketplace. But, in large measure due to the distortions introduced by the tax system, it is not a normal market. Insured persons do not bear directly the costs of the insurance, employers do. More importantly, for insured persons, once relatively small deductibles are met, the marginal cost of consuming health care services are quite small--reaching almost zero once the typical 80/20 co-payment is exhausted (typically at \$1,000 to 2,000 out of pocket). There is very, very little cost consciousness among insured consumers of health care services. If the marginal cost of consuming a good is low relative to other goods, consumers will consume relatively more of it. Moreover, a consumer gains little or nothing, financially speaking, by minimizing the consumption of health care services. The recent Medical Savings Account (MSA) legislation is an attempt to address this problem. The advent of health maintenance organizations (HMOs) and preferred provider organizations or networks (PPOs) have introduced more significant price competition to the marketplace. Price competition in health care is still relatively sedate compared to other markets, however. In addition, HMOs profit from economizing in the delivery of health care where the incentive for health care providers in fee for service insurance systems is to expand the scope of the service being provided. Defensive medicine designed to limit the likelihood of malpractice liability also influences health care providers to provide more services and order more tests than may be

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<sup>15</sup> Ibid.

<sup>16</sup> Organization for Economic and Cooperation Development (OECD), Statistical Abstract of the United States, 1996, Table 1332, p. 834. 1994 figures. *Compare:* Sweden (\$1,348), Canada (\$2,010), Great Britain (\$1,211), France (\$1,866), Germany (\$1,816), Japan (\$1,481) or Spain (\$971).

<sup>17</sup> Note 14, *supra*.

<sup>18</sup> U.S. Bureau of the Census, Statistical Abstract of the United States, 1999, Table 1352, p. 836. 2000 projected figures. *Compare:* Australia (80.4 years), Burkina (45.7 years), Malawi (36.0 years), South Africa (53.9), Zimbabwe (38.6 years).

<sup>19</sup> Ibid. 2000 projected figures. Per 1,000 live births. *Compare:* Afghanistan (137.5), Brazil (33.8), Mexico (23.4), Zimbabwe (60.7).

<sup>20</sup> See, e.g. David M. Cutler, "A Guide to Health Care Reform," *Journal of Economic Perspective*, Summer 1994, Vol. 8, No. 3, pp. 13-29.

warranted. Information about the quality of various health care providers is very difficult if not impossible to come by except anecdotally by word of mouth.

The fact that most health insurance is employer provided means that employees experience reduced choice (the employer buys the insurance not the employee). The health insurance purchased by the employer is unlikely to meet the preferences of all or even many of its employees. It is, as one commentator put it, as if Ford Motor Company could tell you what car to drive.<sup>21</sup> In addition, since health insurance is linked to employment, those who develop health problems may experience health insurance problems relating to “pre-existing conditions” if they attempt to change jobs. Recent legislation was enacted in an attempt to address this problem.

In summary, we have a market where there is restrained price competition, almost no publicly available information about the quality of health care providers, where insured consumers do not bear the financial burden of their purchase decisions and have virtually no incentive to economize in their use of health care services. To carry the car analogy a bit further, it would be as if your employer purchased your car for you but you can decide what extras you want at no cost to yourself (except for the first few hundred dollars). Moreover, you and your employer would have almost no information about the quality of the car, except what you may have heard from your friends, and the price of the car was set by a third party so there wasn't much your employer could do to cut his costs. Trying to compare the health care market to a more conventional market like the automobile market helps illustrate how unusual a market it really is.

The FairTax will eliminate the tax preference for health insurance. Health insurance and medical care would be treated for tax purposes like all other goods and services. This would change considerably the structure of the health care delivery system over time. There would no longer be a large tax reason for employers to provide health insurance although many would probably continue to do so. Employees who preferred to work for an employer who took care of this chore would tend to work for this type of employer. Other employers would undoubtedly choose to get out of the health insurance purchasing business and provide money to their employees to buy their own. Some employees would value the right to purchase the kind of insurance they wanted rather than the kind bought for them by their employers. Individual health insurance policies would probably come down in price as they become more common. Insurers would want to get their share of this growing, although highly price-conscious market. Some individuals might purchase high deductible policies and use their time to shop more aggressively on price or minimize their use of health care, introducing more aggressive price competition to the health care marketplace.

The income tax is embedded in the price of everything we buy. Once the current tax system is repealed, pre-sales tax prices will come down because these embedded tax costs will have been removed. Tax *inclusive* prices, after passage of the FairTax, will remain very close to the prices found in the market place today. Harvard economist Dale Jorgenson estimates that the pre-tax prices in the services industry generally would fall by 25 percent after a sales tax

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<sup>21</sup> Bert Loftman, M.D., “Taxes and Health Care,” Physicians Who Care Newsletter, Vol. 7, No. 1, Winter 1997, p.3.

replaced the current tax system.<sup>22</sup> Prices in most other industries will fall 20 to 25 percent as well. This effect combined with the introduction of a more normal health care market will cause health care costs, even including the sales tax, to come down.<sup>23</sup>

Certainly, the health care marketplace would be very different from what it is today. Health care providers that are more creative and more flexible will fare well in this new competitive environment. Those that are less able to adapt will not do as well. Equally as important, the introduction of a more fluid, competitive marketplace is likely to hold down health care costs and better and more efficiently meet consumers' needs.

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<sup>22</sup> Dale W. Jorgenson, "The Economic Impact of the National Retail Sales Tax," May 1997 prepared for the National Tax Research Committee.

<sup>23</sup> For a more detailed discussion of the impact of a national sales tax on prices see Americans For Fair Taxation's position paper "Impact of the FairTax on Prices."